State of Connecticut
GENERAL ASSEMBLY

Medical Assistance Program Oversight Council
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Medical Assistance Program Oversight Council

Biannual Reports: CY 2016 QTS 1 & 2

Date: July 7, 2016

To: The Connecticut General Assembly

From: Richard Eighme, Administrative Assistant

Subject: MAPOC 2016 Biannual Report

This report of the Council on Medical Assistance Program Oversight is hereby submitted to the Connecticut General Assembly, pursuant of 17b-28 subsec. (i) and in accordance with section 11-4a of the Connecticut General Statutes, subject to the time period of January to June 2016.

Sincerely,

Senator Terry Gerratana
Co-Chair of MAPOC
Chair, Public Health Committee

Representative Cathy Abercrombie
Co-Chair of MAPOC
Chair, Human Services Committee

Richard Eighme
Administrative Assistant

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Biannual Reports

CY 2016 Quarters: 1 & 2

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Acronyms and Abbreviations

AHCT	Access Health Connecticut
AMH	Advanced Medical Home (SIM)
ASO	Administrative Service Organization
AWP	Average Wholesale Price
BHP	Behavioral Health Partnership
BHPOC	Behavioral Health Partnership Oversight Council
CAC	Consumer Access Committee
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Complex Care Committee
CCIP	Community and Clinical Integration Program (SIM)
CCT	Community Care Team
CGA	Connecticut General Assembly
CGS	Connecticut General Statutes
CHA	Connecticut Hospital Association
CHC	Community Health Center
CHC-ACT	Community Health Center Association of Connecticut
CHIP	Children's Health Insurance Program
CHN-CT	Community Health Network of Connecticut
CHW	Community Health Worker
CMAP	Connecticut Medical Assistance Program
CMC	Care Management Committee
CMCS	Center for Medicaid and CHIP Services (CMS)
CMMI	Center for Medicare & Medicaid Innovation (CMS)
CMS	Centers for Medicare & Medicaid Services
DDS	Department of Developmental Services
DCF	Department of Children and Families
DHP	Dental Health Partnership (Also: CTDHP)
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DOC	Department of Correction
DSS	Department of Social Services
EAC	Equity and Access Council (SIM)
EBT	Electronic Benefit Transfers
ED	Emergency Department
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
HIX	Health Insurance Exchange
ICM	Intensive Care Management
ICM	Integrated Care Model
LOB	Legislative Office Building
LMHA	Local Mental Health Authority
LTSS	Long-Term Services and Supports
MAPOC	Medical Assistance Program Oversight Council
MFP	Money Follows the Person
MQISSP	Medicaid Quality Improvement and Shared Savings Program
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
OBP4P	Obstetric Pay for Performance
OEC	Office of Early Childhood
OFA	Office of Fiscal Analysis
OPM	Office of Policy Management
PCMH	Person-Centered Medical Home
PCP	Primary Care Physician
PMO	Project Management Office (SIM)
PNA	Personal Needs Allowance
PTN	Practice Transformation Network
PTTF	Practice and Transformation Taskforce (SIM)
QHP	Qualified Health Plan
QI	Quality Improvement
RFI	Request for Information
RFP	Request for Proposal
SAGA	State Administered General Assistance
SIM	State Innovation Model
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
TFA	Temporary Family Assistance
TMA	Transitional Medical Assistance
VO	Value Options
WIC	Women, Infants and Children

Overview of the Council

The Council on Medical Assistance Program Oversight, referred to as the Medical Assistance Program Oversight Council (MAPOC), biannually reports to the General Assembly as required under CGS 17b-28 subsec. (i). The Medical Assistance Program Oversight Council (previously called the Medicaid Managed Care Council) is a collaborative body established by the General Assembly in 1994 to initially advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A).

Legislation in 2011 revised 17b-28 to include Council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. The statute charges the Council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under Administrative Service Organizations (ASOs), transitional issues from managed care, eligibility standards, benefits, health care access and quality measures.

The Council consists of legislators, consumers, advocates, health care providers, administrative service organization representatives and state agency/commission personnel as defined in statute. An updated membership list can be found at: https://www.cga.ct.gov/med/about-members.asp.

The Council has several sub-committees to give attention to the wide facets of Medical Assistance. They include the Consumer Access, Care Management, Women's Health, Quality Improvement and Complex Care Committees. Sub-committees are comprised of members of MAPOC and ex-officio persons, whose knowledge and expertise provide advisement to the particular subject matter of Medical Assistance. Depending on the needs of the Council subcommittees meet monthly, bimonthly and Ad-Hoc.

In 2014 the standing subcommittee on Cost Savings was established, under CGS 17b-28 subsec. (h), to make annual recommendations to the Council on evidence-based best practices concerning Medicaid cost savings. Membership of this standing subcommittee is defined in Statute. In 2016 a standing subcommittee was established under CGS 17b-28 subsec. (k), to make recommendations to the Council on children and adults with complex health care needs. This subcommittee is required to report on the efficacy of support systems for children and young adults with developmental disabilities in accordance with Sec. 11-4a.

Records of the Council and sub-committee meetings are kept on file in the Public Health Joint Standing Committee of the Connecticut General Assembly and are all available on the MAPOC website at www.cga.ct.gov/med/. Information about the Council, updates, additional documents and useful links can also be found on the webpage.

Section 17b-28 CT General Statutes

As Amended by: Public Act No. 16-3 and Public Act No. 16-142

Sec. 17b-28. Council on Medical Assistance Program Oversight. Duties. Appointments. Funding. Standing subcommittee. Reports. (a) There is established a Council on Medical Assistance Program Oversight which shall advise the Commissioner of Social Services on the planning and implementation of the health care delivery system for the following health care programs: The HUSKY Plan, Parts A and B and the Medicaid program, including, but not limited to, the portions of the program serving low income adults, the aged, blind and disabled individuals, individuals who are dually eligible for Medicaid and Medicare and individuals with preexisting medical conditions. The council shall monitor planning and implementation of matters related to Medicaid care management initiatives including, but not limited to, (1) eligibility standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome measures, and (6) the issuance of any request for proposal by the Department of Social Services for utilization of an administrative services organization in connection with such initiatives.

(b) On or before June 30, 2011, the council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees; two members of the General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; a representative of each organization that has been selected by the state to provide managed care and a representative of a primary care case management provider, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance use disorders, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; and one representative of the office of the State Comptroller, to be appointed by the State Comptroller.

(c) On and after July 1, 2011, the council shall be composed of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services, public health and appropriations and the budgets of state agencies, or their designees;
(2) Five appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly, one of whom shall be a community provider of adult Medicaid health services, one of whom shall be a recipient of Medicaid benefits for the aged, blind and disabled or an advocate for such a recipient, one of whom shall be a representative of the state's federally qualified health clinics and one of whom shall be a member of the Connecticut Hospital Association;
(3) Five appointed by the president pro tempore of the Senate, one of whom shall be a member of the General Assembly, one of whom shall be a representative of the home health care industry, one of whom shall be a primary care medical home provider, one of whom shall be an advocate for Department of Children and Families foster families and one of whom shall be a representative of the business community with experience in cost efficiency management;
(4) Three appointed by the majority leader of the House of Representatives, one of whom shall be an advocate for persons with substance abuse disabilities, one of whom shall be a Medicaid dental provider and one of whom shall be a representative of the for-profit nursing home industry;
(5) Three appointed by the majority leader of the Senate, one of whom shall be a representative of school-based health centers, one of whom shall be a recipient of benefits under the HUSKY program and one of whom shall be a physician who serves Medicaid clients;
(6) Three appointed by the minority leader of the House of Representatives, one of whom shall be an advocate for persons with disabilities, one of whom shall be a dually eligible Medicaid-Medicare beneficiary or an advocate for such a beneficiary and one of whom shall be a representative of the not-for-profit nursing home industry;
(7) Three appointed by the minority leader of the Senate, one of whom shall be a low-income adult recipient of Medicaid benefits or an advocate for such a recipient, one of whom shall be a representative of hospitals and one of whom shall be a representative of the business community with experience in cost efficiency management;
(8) The executive director of the Commission on Women, Children and Seniors, or the executive director's designee;
(9) A member of the Commission on Women, Children and Seniors, designated by the executive director;
(10) A representative of the Long-Term Care Advisory Council;
(11) The Commissioners of Social Services, Children and Families, Public Health, Developmental Services and Mental Health and Addiction Services, and the Commissioner on Aging, or their designees, who shall be ex-officio nonvoting members;
(12) The Comptroller, or the Comptroller's designee, who shall be an ex-officio nonvoting member;
(13) The Secretary of the Office of Policy and Management, or the secretary's designee, who shall be an ex-officio nonvoting member; and
(14) One representative of an administrative services organization which contracts with the Department of Social Services in the administration of the Medicaid program, who shall be a nonvoting member.

(d) The council shall choose a chairperson from among its members. The Joint Committee on Legislative Management shall provide administrative support to such chairperson.

(e) The council shall monitor and make recommendations concerning: (1) An enrollment process that ensures access for each Department of Social Services administered health care program and effective outreach and client education for such programs; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of accessible adult and child primary care providers, specialty providers and hospitals in Medicaid provider networks; (4) the sufficiency of provider rates to maintain the Medicaid network of providers and service access; (5) funding and agency personnel resources to guarantee timely access to services and effective management of the Medicaid program; (6) participation in care management programs including, but not limited to, medical home and health home models by existing

community Medicaid providers; (7) the linguistic and cultural competency of providers and other program facilitators and data on the provision of Medicaid linguistic translation services; (8) program quality, including outcome measures and continuous quality improvement initiatives that may include provider quality performance incentives and performance targets for administrative services organizations; (9) timely, accessible and effective client grievance procedures; (10) coordination of the Medicaid care management programs with state and federal health care reforms; (11) eligibility levels for inclusion in the programs; (12) enrollee cost-sharing provisions; (13) a benefit package for each of the health care programs set forth in subsection (a) of this section; (14) coordination of coverage continuity among Medicaid programs and integration of care, including, but not limited to, behavioral health, dental and pharmacy care provided through programs administered by the Department of Social Services; and (15) the need for program quality studies within the areas identified in this section and the department's application for available grant funds for such studies. The chairperson of the council shall ensure that sufficient members of the council participate in the review of any contract entered into by the Department of Social Services and an administrative services organization.

(f) The Commissioner of Social Services may, in consultation with an educational institution, apply for any available funding, including federal funding, to support Medicaid care management programs.

(g) The Commissioner of Social Services shall provide monthly reports to the council on the matters described in subsection (e) of this section, including, but not limited to, policy changes and proposed regulations that affect Medicaid health services. The commissioner shall also provide the council with quarterly financial reports for each covered Medicaid population which reports shall include a breakdown of sums expended for each covered population.

(h) There is established, within the Council on Medical Assistance Program Oversight, a standing subcommittee to study and make annual recommendations to the council on evidence-based best practices concerning Medicaid cost savings. The subcommittee shall file its first report to the council not later than January 1, 2015. The subcommittee shall consist of the following members, whose work on the council shall consist solely of work on the subcommittee:
(1) One appointed by the speaker of the House of Representatives, who shall be a member of the Connecticut Hospital Association;
(2) One appointed by the president pro tempore of the Senate, who shall be a representative of the business community with experience in cost efficiency management;
(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the for-profit nursing home industry;
(4) One appointed by the majority leader of the Senate, who shall be a physician who serves Medicaid clients;
(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the not-for-profit nursing home industry; and
(6) One appointed by the minority leader of the Senate, who shall be a representative of the business community with experience in cost efficiency management.
(i) The subcommittee established pursuant to subsection (h) of this section shall choose chairpersons from among its members.
(j) The council shall biannually report on its activities and progress to the General Assembly.
(k) There is established, within the Council on Medical Assistance Program Oversight, a standing subcommittee to study and make recommendations to the council on children and adults who have complex health care needs. The subcommittee shall consist of council members appointed by the chairpersons of the council and other individuals who shall serve for terms prescribed by the cochairpersons to advise the council on specific needs of children and adults with complex health care needs. For the purposes of completing the reports required pursuant to subparagraphs (A) and (B) of this subsection, such individuals shall include, but need not be limited to: (1) The Child Advocate, or the Child Advocate's designee; (2) a family or child advocate; (3) the executive director of the Council on Developmental Disabilities, or the executive director's designee; (4) the executive director of the Connecticut Association of Public School Superintendents, or the executive director's designee; (5) an expert in the diagnosis, evaluation, education and treatment of children and young adults with developmental disabilities; and (6) the Healthcare Advocate, or the Healthcare Advocate's designee. The subcommittee shall submit the following reports, in accordance with section 11-4a to the council, the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to children, human services and public health regarding the efficacy of support systems for children and young adults, not older than twenty-one years of age, with developmental disabilities and with or without co-occurring mental health conditions:

(A) Not later than July 1, 2017, recommendations including, but not limited to: (i) Metrics for evaluating the quality of state-funded services to such children and young adults that can be utilized by state agencies that fund such services; (ii) statutory changes needed to promote effective service delivery for such children and young adults and their families; and (iii) any other changes needed to address gaps in services identified by the subcommittee or council with respect to such children, young adults and their families; and

(B) Not later than January 1, 2018, an assessment of: (i) Early intervention services available to such children and young adults in this state; (ii) the system of community-based services for such children and young adults; (iii) the treatment provided by congregate care settings that are operated privately or by the state and provide residential supports and services to such children and young adults and how the quality of care is measured; and (iv) how the state Department of Education, local boards of education, the Department of Children and Families, the Department of Developmental Services and other appropriate agencies can work collaboratively to improve educational, developmental, medical and behavioral health outcomes for such children and young adults and reduce the number at risk of entering institutional care. As used in this subsection, "developmental disability" means a severe, chronic disability of an individual, as defined in 42 USC 15002, as amended from time to time.

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On January 8th, the Council received a report from the Department of Social Services (DSS) on Connecticut's Medicaid Financial Trends. The Department also provided an update on Eligibility and the ConneCT Public Dashboard. The Council approved the MAPOC 2015 Biannual Report.
Attachments:

- Medicaid Financial Reports and Trends
- ConneCT Quarterly Update
- Final Draft of MAPOC 2015 Biannual Report

On February 19th, the Council received an update on the transition of the HUSKY A parents who lost Medicaid eligibility from the Department of Social Services and Access Health CT. CT Voices for Children provided a presentation on dental care for children in the HUSKY Program.
Attachments:

- HUSKY A Parent Transition Update
- Dental Care for Young Children in the Husky Program

On February 22nd, the Council helped support and promote a joint forum for the Human Services Committee, in conjunction with the Appropriations, Public Health and Aging Committees, on Connecticut's Medicaid Expenditures, Initiatives and Long-Term Services and Supports Rebalancing.
Attachments:

- Department of Social Services Presentation
- CT 21 and CBIA Presentation

On March 11th, the Council received an overview of the Connecticut Medicaid access plan and Medicaid medical care advisory committee from DSS. BeneCare provided an update on the Connecticut Dental Health Partnership. Access Health CT and DSS provided an update on outreach efforts for the HUSKY A Parent transitions.
Attachments:

- CT Medicaid Access Plan and Medicaid Medical Care Advisory Committee Presentation
- CT Dental Health Partnership Presentation
- HUSKY A Outreach Efforts and Communication Plan Executive Summary
- HUSKY A Outreach Schedule

On May 20th, the Council received the quarterly ConneCT Public Dashboard Update. Access Health CT and DSS provided the quarterly update on the Transition of HUSKY A Adults. CT Voices for Children provided research on the HUSKY A income eligibility cut.
Attachments:

- ConneCT Quarterly Update
- HUSKY A Parent Transition Update
- HUSKY Income Eligibility Cut, CT Voices for Children

On June 10th, DSS provided an overview of the Innovation Accelerator Program on Medicaid-Housing Partnership and an update on the HUSKY Plus Program. The Council discussed the proposed 15 percent reduction to Medication Administration rates.
Attachments:

- Innovation Accelerator Program on Medicaid-Housing Partnerships Presentation
- HUSKY Plus Presentation

DSS Medication Administration Cover Letter
DSS Medication Administration Issue Brief

Care Management Committee

On January 12th, the committee held a MQISSP workgroup on the participation of Non-DSS PCMH primary care practices in MQISSP advanced networks, the proposed communication plan materials development phase and the DSS program oversight plan.

On January 13th, DSS and CHN provided a PCMH update and provided several documents on quality measures. The committee reviewed MQISSP documents pertaining to the participation of Non-DSS PCMH primary care practices in MQISSP advanced networks, the proposed communication plan materials development phase and the DSS program oversight plan.

Attachments:

- PCMH Update Presentation
- Measure Set for PCMH Performance Payment 2016 DRAFT
- PCMH Quality Measures Showing Retired
- PCMH Quality Measures with Proposed New Measures Highlighted DRAFT
- Participation of Non-DSS PCMH Primary Care Practices in MQISSP Advanced Networks DRAFT
- Proposed Communication Plan Material Development Phase DRAFT
- DSS Program Oversight Plan DRAFT

On February 2nd, the SIM PTTF held a joint meeting with the Care Management Committee on CCIP's integration in MQISSP.

Attachment:

- CCIP Presentation

On February 9th, the committee held a MQISSP workgroup on the PCMH Issue Paper and Shared Savings Payment Principles.

On February 10th, the committee reviewed MQISSP documents pertaining to the PCMH Issue Paper and Shared Savings Payment Principles. Discussion was had on the integration of CCIP into MQISSP. The monthly presentation on PCMH was distributed but not presented.

Attachments:

- MQISSP CCIP Crosswalk
- CCIP Standards with MQISSP Elements Highlighted
- PCMH Advanced Networks Issue Paper
- Shared Savings Payment Principles
- PCMH Update Presentation

On February 16th, the committee help a CCIP workgroup to further discuss the programs integration into MQISSP.

On March 2nd, Mercer and DSS held a MQISSP webinar on shared savings calculations.

On March 15th, the committee held a MQISSP workgroup on PCHM attribution and MQISSP member assignments.

On March 16th, SIM provided an update on the CCIP standards. The committee reviewed a report on PCHM attribution and MQISSP member assignments. The committee received the MQISSP shared savings calculation webinar, extended timeline, draft welcome letter and assignment scenarios.
Attachments:

CCIP Summary of Response to Concerns
CCIP Response to Questions and Concerns
PCMH Attribution Issue Paper
MQISSP Member Assignments
Shared Savings Calculation Webinar
MQISSP Timeline
MQISSP Draft Welcome Letter
MQISSP Assignment Scenarios

On April 13th, DSS and CHN provided a PCMH update which included a report that sorted provider's specialty by program. The committee reviewed and discussed the MQISSP proposed quality measure list.
Attachments:

PCMH Update
PCMH Provider Specialty by Program
MQISSP Proposed Quality Measure List

On May 10th, the committee held a MQISSP workgroup on the MQISSP proposed quality measure list and draft member welcome letter.

On May 11th, DSS and CHN provided a PCMH update which included a report on performance based payments. The committee reviewed and discussed the MQISSP proposed quality measure list and draft member welcome letter.
Attachments:

PCMH Update with Performance Based Payments Report
MQISSP Proposed Quality Measure List
Draft MQISSP Member Welcome Letter

On June 16th, the committee held a MQISSP workgroup on the member welcome letter.

Complex Care Committee

On January 22nd, DDS and CHN gave a presentation on waiver services and ICM. A presentation was given on Medicaid Radiology Rates.
Attachments:

DDS Presentation
Intensive Care Management Presentation

DDS Waiver Overview
Medicaid Radiology Reimbursement Presentation

On February 26th, executive members of the Complex Care Committee met to discuss future meeting topics.

On March 18th, DSS provided an update on the High Need, High Cost Policy Academy and provided a draft sample of data. The Commission on Aging gave a presentation on livable communities

Attachments:

Draft High Need, High Cost Data
Commission on Aging Presentation

On May 9th, the committee hosted a webinar on Palliative Care.

Attachments:

Webinar PowerPoint
Webinar Video

On May 27th, the committee met to follow-up on the Palliative Care webinar, and Radiology utilization rates. DSS provided an update on the High Need, High Cost Policy Academy and a brief overview of the Innovation Accelerator Program on Medicaid-Housing Partnerships.

Attachments:

Radiology Utilization Letter to PH and HS Leadership
NGA Data Summary Cohorts
NGA Data Summary Population Breakdown

On June 24th, the committee received an overview of some potential issues with Workers Compensation and Medicaid Cost Shifting. The Center for Medicare Advocacy provided a presentation on Medicare - Medicaid Cost Shifting.

Attachment:

Medicare, Medicaid Cost Shifting Presentation

Consumer Access Committee

On January 27th, the committee met jointly with the Coordination of Care Committee (BHPOC) and received an overview of the integration of behavioral health and physical health from DMHAS.

Attachment:

Integration of Behavioral Health and Physical Health Presentation

On March 23rd, the committee received a presentation on Person Centered Medical Homes (PCMH).

Attachment:

PCMH Presentation

On May 25th, the committee received an update on Non-Emergency Medical Transportation from Logisticare.

Attachment:

NEMT Presentation

Women's Health Committee

On January 11th, a presentation was given on the shackling of women during labor and delivery in the prison system.
Attachments:

- Shackling of Pregnant Women Presentation
- Best Practices of Use of Restraints
- Mothers Behind Bars State Report Card
- Session Laws: Chapter 103 of the Acts of 2014

On March 14th, the committee received a presentation from the Connecticut Coalition Against Domestic Violence (CCADV).
Attachments:

- CCADV Presentation
- CCADV Handout

On June 13th, the committee met to discuss the issue of opioid abuse during pregnancy.

Appendix A

MEETING MINUTES

Friday, January 8, 2016

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:37 AM by the chair, Rep. Abercrombie. She welcomed everyone to the first meeting of the New Year.

Introductions are made by those in attendance.

IIA. Kate McEvoy of DSS gave a brief context overview of Connecticut's Medicaid Model and what the presentation on Medicaid Financial Trends would show. Mike Gilbert of DSS began the presentation (See Attachment).
https://www.cga.ct.gov/med/council/2016/0108/20160108ATTACH_Medicaid%20Trends%20Presentation.pdf

The Presentation provided an update to the October 2014 review, a summary of monthly DSS reports to MAPOC, a review of major Medicaid enrollment, expenditure and per member per month trends, a review of aggregate, state and federal Medicaid spending in CT and a comparison of national benchmarks.

Sharon Langer requested that it should be noted that Husky A includes children and that its important to show the difference of expenditures.

Mark Maselli asked how the money is shifted under the Affordable Care Act based on time of eligibility.

Sharon asked that information on Husky B reimbursement and CHIP funding for children also be included in the presentation. Sheila Amdur talked about misunderstanding in the legislature on costs and the need to depict what the state's share is in Medicaid spending. Kate talked about the gaps in appropriations and cost shifts from the federal government to the state.

Ellen Andrews talked about nationally PMPM compared to CT and the good news for our state.

Stephen Frayne asked that expenditures also be displayed by provider taxes along with the State and federal share.

Ellen commented on the good information provided during the presentation and the money being saved. She discussed the data and results and the success of the model. Kate discussed Connecticut's success in rebalancing.

Matthew Barrett shared his belief that the chart on p. 17 depicts positive financial implications for the state.

Mike added clarification on the reimbursement from the federal government which will decrease by about half a percent in the State Fiscal Year 2017.

Deb Migneault added comments on MFP and improvements in data on quality of life. Rep. Abercrombie thanked Deb and discussed the focus on the budget. Sheila Amdur added comments on Husky C and the high cost high need of this population which leads to disparities in spending.

Deb Polun asked if there were similar questions asked to other recipients of Medicaid on quality of life and expressed the need to prioritize on quality. Rep. Abercrombie discussed wanting to serve as many people as possible and prioritize based on budget restraints. Kate went over the mission of DSS and wanting to circulate a document that discusses economic wellbeing and health care coverage with preventative services. Rep. Abercrombie shared her appreciation for the work at DSS and wanting to support the Department financially while acknowledging budget restrictions. Dr. Zavoski discussed the term investment which is vital to the Medicaid program and its future.

Sharon Langer discussed the role back in eligibility in Husky A and needing to survey those losing coverage before and after the cuts to get a better understanding of what happens indirectly when people lose services. Ellen stated that the last time people were cut from services they weren't able to do surveys but discussed some of the outcomes that happened based on families that were followed. She discussed Medicaid not being a problem in the state budget and a false understanding of the cost vs. outcomes.

Rep. Abercrombie thanked Mike for the report and asked that future meetings show numbers broken down by population.

IIB. Kate McEvoy introduced Melissa Garvin who is the director of tactical planning and field operations at DSS. She went through the presentation which provided a year in review of field operations, online accomplishments and the January Dashboard (See Attachment). https://www.cga.ct.gov/med/council/2016/0108/20160108ATTACH_ConneCT%20quarterly%20update%20-%20Copy.pdf

Rep. Abercrombie asked if the process for when calls come in was changed. Melissa referenced a chart that was handed out in showing the process and how the calls were done.

Deb Polun asked what programs could be accessed through the online portal.

Sen. Gerratana received clarification on the user ID and the client ID needing to be linked.

Kristen Hatcher asked about the reporting during predictable times and the time frame for items that needed to be followed up on. Melissa clarified that considerable processing that is not necessary during high volume times can wait and are resolved same day. Generally high times are during the beginning and end of the months.

Molly Rees-Gavin asked for clarification on slide 3 and what the percentages referred to. Melissa referenced that the numbers are separated base on the standard of promptness.

Ellen asked what the threshold was on calls abandoned. The threshold is 20 seconds.

Stephen Frayne complimented on the benefit center wait times and asked if there was a goal. Melissa talked about process improvement and the skews in wait times. DSS is working on finding an acceptable range.

Christine Bianchi asked for a clearer understanding on renewals that cannot happen online. Melissa talked about the scanning center metrics and staff that are specifically assigned to renewals.

Deb Polun asked if the next time there was a presentation someone from Access Health could be invited and able to answer questions.

Rep. Johnson asked how the data is being made available on a regular basis and why someone might be left with a long ringtone. Melissa talked about the different systems but not understanding a long ringtone. She added that the dashboard is posted online each month.

Mark Masselli asked what the average amount of time people are on the phone after a call is answered. Melissa stated that each case depends but on average about 14 to 16 minutes. The figures are fairly consistent and shifts happen based on predicted processing times. Mark asked for that trend to be shared.

Kate added comments and provided details on the availability of information available.

Sharon Langer asked about the first report for the category of services that are provided and if it includes behavioral health services. The report is inclusive of all expenditures. Sharon asked if there was a reason transportation was left out. Mike stated that the report is a snapshot of a much larger and more specific report. Sharon asked that maybe a note be added stating that. Ellen added that you have to ask for the Comprehensive Financial report from DSS and asked if that could be added to the site along with the active assistance reports and quarterly numbers on enrollment by category. Kate said that she would talk to the commissioner and report back.

Kristen followed up with Mark's comments and asked about process improvements vs. efficiencies and the possibility of being able to see that data. Melissa stated that staff is not shifted and added comments on leaning the process and being more proactive.

Sheila Amdur talked about the standard with Logisticare and the standards that they had to meet and the possibility of setting a benchmark for benefit centers. Melissa talked about the difference of the two services. Rep. Abercrombie added that she feels that trying to set specific wait times will cause shifting that may take away from other services.

Rep. Abercrombie asked that it might help to have a breakdown of staffing in the three service areas.

III. Subcommittee Report (See Attachment)
https://www.cga.ct.gov/med/council/2016/0108/20160108ATTACH_December%20-January%20Subcommittee%20Report.pdf

Rep. Abercrombie talked about the discussion on reporting from the subcommittees. Christine invited people to feel free to suggest topics for the consumer access or other subcommittees. Rep. Abercrombie added that she would be looking at the subcommittees and what is happening in them.

Rep. Johnson provided an update on the complex care committee and the development of an informational forum. She talked about cost shifts that the committee will look at. Matt Katz talked about the notes that were shared from the complex care committee and the savings CBIA has publicized. He asked Kate if this savings existed. Kate talked about misconceptions on the rebalancing initiative of DSS and the document that has been distributed on long-term services and supports rebalancing by the Department.

Rep. Abercrombie thanked the chairs of Complex Care for bringing the information forward and deciding to move ahead with the forum. Deb Migneault stated that the Commission on Aging did meet with CBIA and tried to provide them with the most up-to-date and relevant information. Rep. Abercrombie thinks it will be important to invite CBIA to the forum. Sheila talked about the climate today and the forum needing to be framed in a way that was short and to the point. Kate stated that DSS wants to invite people to share where they think large amounts of savings may be found and talked about current discussions on e-consults and the possible benefits.

Rep. Abercrombie complimented DSS on being open and at the table. Sharon added her hope that the BHPOC be included in talks.

IV. Final Report (See Attachment)
https://www.cga.ct.gov/med/council/2016/0108/20160108ATTACH_Final%20Draft-%202015%20Council%20Biannual%20Report%20-%20Full.pdf

Rep. Abercrombie went over the final report and the one change that was made. She thanked the clerk for his work on the report. She asked for a voice consensus of approval of the report. The report was accepted unanimously.

Rep. Abercrombie announced the date of the next meeting and asked the Council to pay close attention to where the meetings would take place due to session restraints. She went over what would be on the agenda for next month.

With no other business, Rep. Abercrombie thanked all the members.

The meeting was adjourned at 12:03 AM.

MEETING MINUTES

Friday, February 19, 2016

9:30 AM in Room 1B of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:33AM by the chair Sen. Gerratana. She thanked everyone for their attendance and discussed the legislative process. Sen. Gerratana apologized for the limited capacity of the room, which was the only one available for the meeting.

Introductions were made by those in attendance.

II. Marc Shok began the DSS and AHCT presentation with Rob Blundo (See Attachment). Marc explained Public Act 15-5 and the reporting requirements he would be sharing.
https://www.cga.ct.gov/med/council/2016/0219/20160219ATTACH_HUSKY%20A%20Transitions%20.pdf
Rob Blundo went through the rest of the data in the presentation.

Kristen Hatcher asked if the number of children who were unenrolled based on their parents un-enrollment was known. Marc Shok explained that in theory the parent's enrollment would not affect their children's and that the metric would be difficult to obtain. Sen. Gerratana asked for clarification on why the metric would be difficult to obtain. Marc discussed working over two systems and how cases are sorted in the Husky A program. He added clarification on the unique identifiers used for different populations within the Medicaid program.

Ellen Andrews talked about 12 families who were followed for a year the last time coverage was lost and the 3 circumstances where children lost coverage. She went through the percentages which showed about half of the first cohort of persons no longer having health coverage. Marc stated that it was a significant amount that needed improvement but there could be circumstances that persons have coverage outside of Medicaid or Quality Health Plans, DSS and AHCT would not be able to track.

Katherine Yacavone asked for clarification on p. 6 and what the process would be when the TMA ends. Marc talked about the coverage that would be lost and the outreach that will be done. The coverage of children remains the same.

Mary Alice Lee asked if the plans could be discussed more. Marc talked about what was done last summer for the 1,215 and the person to person outreach used. He stated that they plan to do the same for the 17,000+ that lose their TMA coverage effective August 1, 2016. Recipients need to make sure their information is up-to-date. Many techniques will be used including person to person interactions, robo-calls and postcards. DSS and AHCT have had many meetings on strategizing and finding the best way to reach out to these people and encouraging them to enroll in QHPs. Rob Blundo added that it's important to keep the individuals well educated. He stated that retention is important in making it easy for individuals to maintain health coverage. Premium payments must be made and eligibility information must be completed to retain

insurance. There is outreach going to targeted people with outstanding information and AHCT is working with community partners.

Rev. Bonita Grubbs shared her interested in the use of community partners and requested more information on the outreach.

Stan Soby asked why children's coverage could not be identified and why the outreach effort couldn't include helping parents assist their children. Marc said they could factor in outreach on children but identifying the children would be difficult based on the system and a possible lack of resources based on IT. Stan added that a sampling might be useful to see if there is a significant number.

Cynthia DelFavero asked if DSS would be switching in August to its new ImpaCT system. The Commissioner recently announced that ImpaCT would be delayed and will begin the pilot role out in the fall. Cynthia asked for clarification on community organizations involvement. Marc talked about the communication used. Cynthia discussed current access to the EMS system. Marc explained that access to EMS is being watched very closely and will influence the transition to ImpaCT. Cynthia explained that in order to help a consumer, having access to EMS is necessary for organizations, especially with the 17,000 plus losing coverage. She made the point that it would help to have as much information as possible.

Alex Geertsma talked about the relationship between parent coverage and their children's coverage and how the system doesn't have the relationship to connect the coverage between families. With private insurance you could track the families because of how dependents are set up. He expressed his hope that SIM addresses this and the problems clinicians have when trying to contact parents without having proper information.

Katherine explained how through attribution, if parents are going through community health centers they would be able to make connections. They need help to reach out to these families.

Rep. Abercrombie asked that there be a plan in place. She explained the extensiveness of this population and the outreach needed. She added that Sen. Gerratana and she were also very concerned about the kids. Rep. Abercrombie asked that when DSS and AHCT come back next month they have a plan to share. She stated not wanting to be looking back thinking we did the best we could when more could have been done. Sen. Gerratana reflected the concerns of the Council and legislation. Mary Alice added that she would like to see how they would staff up to deal with the additional people and the messages that need to go out. She questions what happens if people don't get coverage in time but want coverage outside of enrollment.

Sen. Gerratana requested more information on how someone enrolls outside of the enrollment period.

Kristen Hatcher stated that notices will be a critical component when the TMA expires and explained how notices can have conflicting and confusing messages.

Rep. Johnson added that she wants to see more information on the process of enrollment and the process of becoming eligible for Medicare or other services. Marc Shok talked about the transition and the automated process that would be used in the future. Marc explained certain persons would have the option to enroll in QHCs with a subsidy.

Cynthia asked Rob Blundo on the training/ education for brokers and mistakes that she knows have happened because people go to enroll when they already have coverage on Medicare. Rob added that with a subsidy there are checks that are performed with the federal data check services. If brokers are selling insurance to those who already coverage, Rob asked to get the names of individuals so they can do research. Sen. Gerratana asked why a Medicare recipient wouldn't be automatically stopped. Rob talked about working credits and lacking subsidies. There are a small number of individuals who have QHP and who don't get the coverage of Medicare. Dr. Geertsma discussed the industry of private insurers who receive commission and the concerns of receiving advice that is steered towards consumers in a way for them to make money. The brokers in Connecticut are required to register through Access Health CT and file forms that agree to a code of ethics.

Rep. Johnson asked about the interim period of 24 months when someone is disabled but not eligible for Medicare and if the insurance commissioner was aware of some of these issues. She provided an example of a constituent who purchased additional coverage. Mark talked about disabled individuals being able to receive HUSKY D if they are not receiving Medicare. Additionally if they have children they could receive Husky A.

Jesse White-Frese asked if coverage goes both ways for DSS and AHCT. Marc added clarification on the rules of eligibility between the two systems and needing to have a case through EMS. It is currently not automated but will be under Impact. The EMS system's case supports automation but the Access Health system holds the case. If a consumer loses eligibility it goes through AHCT and DSS. ImpaCT will help with the eligibility.

Sen. Gerratana thanked DSS and Access Health for their presentation and discussed what needed to be looked into.

III. Mary Alice Lee began her presentation and provided context of the project. (See attachment) https://www.cga.ct.gov/med/council/2016/0219/20160219ATTACH_Dental%20Care%20for%20Young%20Chldren%20.pdf

Dr. Geertsma gave comments on the rates of providers participating, his experience in the sites he has worked and the numbers that are attributed. He finds it to be a burden to add more and more to the daily routine of providers and there needs to be other solutions.

Ellen provided her understanding of the burden on providers but wanted to know the saving of money that is taking place and how it could be replicated.

Dennis Cleary asked about the training of practitioners. He questioned if more people are being trained and coming in based on the results. Mary Alice talked about the outreach. Kate said the information would be provided next month.

Jesse White-Frese commented on the remarkable gains that have been made in dental services. She talked about her experiences with not getting reimbursed in a school based health center. Kathy Yacavone added comments on her experience.

Dr. Zavoski stated that the program is a work in progress and the trajectory is consistently up. One of the benefits of the SIM project is to look at what commercial payers are and are not doing. Many private practitioners don't think that Medicaid would pay for these services.

Stan Soby noted the significant data that was presented and asked about participation for urban centers out to the more rural communities.

Alex clarified his comments and added that he thought it was important to look at what goes on in the practices. He questioned the disincentive of not being paid being removed, and what are the other disincentives and solutions would be.

Deb Poerio thanked DHP and DSS for the wonderful program and the opportunity in School based health centers. She believes there is the opportunity to do more of this if resources and training is expanded.

Dennis asked why the cap was set at 48 months. Dr. Zavoski stated what the goal of the program was. Kate apologized for Marty's absence and added he would give a clear answer next month.

Alex stated that the reason to do this in this age group is to capture and prevent.

Rep. Abercrombie thanked Mary Alice for her report and the benefits such gives to law makers when making policy.

IV. Subcommittee Report (See Attachment)
https://www.cga.ct.gov/med/council/2016/0219/20160219ATTACH_January%20-%20February%20Subcommittee%20Report.pdf

Rep. Abercrombie provided information on the MAPOC executive committees work on subcommittees and their structure. Rep. Johnson's thanked everyone for their hard work.

Ellen Andrews talked about the work that is being done on MQISSP in the Care Management Subcommittee. She explained a new issue that came up regarding CCIP. The program was originally thought to be a compliment to MQISSP but currently it will be included in the RFP and CMC members have expressed serious concerns about the costs. Ellen explained that she and others are still trying to understand and work through the project and the different interpretations. Kate provided context on the development of MQISSP and the work that the committee and DSS have been doing. She discussed the structure and idea of building on PCMH. The PTTF has been working on two projects; one is CCIP which contains two components. Kate explained the role of AMHs in the project and the idea of establishing a set of standards for advanced networks. The Department agreed to integrate CCIP into the RFP for MQISSP. She explained that it is very important that Care Management participate in the development of MQISSP and discussed some of the concerns that were expressed on CCIP during the work group. One concern was that CCIP standards don't acknowledge the current work in Medicaid and PCMH. There needs to be more discussion, but there is a schedule for the model design. Suzanne Lagarde commented that one of the associations received a grant from CMS specifically for practice transformation and that efforts are underway.

Alex expressed that he would like everyone to understand the measurement standards for pediatrics was a compromise. He added that there are some things that won't necessarily give cost savings and quality improvement is never done.

Ellen acknowledged the work that Care Management Committee, Mercer and DSS have done on MQISSP. She expressed the need be very careful moving forward to make sure there are no unintended outcomes. Additional resources are needed.

Rep. Abercrombie shared her agreeance with the comments of Kate and Ellen and the time and effort that has gone into MQISSP over the past few months. She thanked the members of Care Management and DSS who despite a lack of resources and time have really stepped up. Rep. Abercrombie added that social services are too important and the need to make sure the Medicaid population is protected.

Kate thanked the chairs, and members for all the time spent in meetings. She thanked the clerk for handling the material and meetings. Kate talked about the need for transparency and the documents all being posted online. She asked the clerk to circulate the developed infographic which shows how all of the Medicaid programs link together.

Suzanne asked about the cost savings subcommittee. The clerk provided details on the status and future plans for the subcommittee. Rep. Abercrombie provided further details and expressed her opinion on the subcommittee.

Kate announced the Medicaid informational forum that would take place on Monday.

Beth Cheney gave information on a group that got together on ICM and didn't have experience. She reached out to them and got very good feedback. Beth would like to have ICM come and share information and the great things that can come of it.

V. Rep. Abercrombie announced the date of the next meeting and asked the Council to pay close attention to where the meetings would take place. She went over what would be on the agenda for next month.

With no other business, Rep. Abercrombie thanked all the members.

The meeting was adjourned at 11:40 AM.

MEETING MINUTES

Friday, March 11, 2016

9:30 AM in Room 2E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:38AM by the chair, Rep. Abercrombie. She thanked everyone for being present.

Introductions were made by those in attendance.

II. Kate McEvoy gave an overview of the two part presentation and discussed the responsibility and accountability of DSS. She began the presentation on the Connecticut Medicaid Access Plan (See Attachment).
https://www.cga.ct.gov/med/council/2016/0311/20160311ATTACH_%20Medicaid%20Access%20Plan%20and%20Medicaid%20Medical%20Care%20Advisory%20Committee%20Presentation.pdf

Joel Norwood walked through the requirements from CMS and the Department's implementation.

Ellen Andrews asked several questions including, if slide 5 could display the trend and not just last year's numbers, if everything would be made available for public comment and state funded services and if DSS will be evaluating the impact after a reduction is made. Kate stated that they are looking at other state's access plans. It is anticipated that all of the information will be made public and because of the deadline it would not be realistic to include the state funded services. DSS is required to show are plans refreshed every two years. Kate added that access is continuously monitored. She talked about the reduction in radiology rates and that DSS is not able to substantiate any data that shows negative impacts.

Sen. Gerratana asked if providers will have to participate in this plan and if they could be surveyed. Kate talked about the requirements of federal law and the intent to include providers in the process. She asked the committee with help in getting the word out. The ASO's have a provider relations unit and Kate discussed the many things in place to monitor provider comments. She reiterated help in promoting the comment period on the access plan.

Sen. Gerratana asked how DSS would be able to follow the access. Joel explained what DSS has been doing for over the past four years with CMS. He talked about the questions they ask. DSS and CMS start with a baseline and then methodologies are and will continue to be developed. Sen. Gerratana asked to have this presented to MAPOC at a future meeting.

Mary Alice Lee asked to follow up on MAPOC and its role. She recommended that there be a representative from MAPOC and BHPOC when developing the plan. Kate thanked Mary Alice for her comments and suggested she talk to leadership about establishing a more affirmative role for the Council.

Tracy Wodatch stated that the Home Health Care providers would be putting in comments. She finds the most important piece is the very experienced providers who are altering how they provide. DSS might not see an access issue but there could be a problem with access to quality and experienced providers. Kate wants the process to be inclusive and finds Tracy's point on elements that may not be measured well taken. She talked about some of what data DSS collects and that they are acutely aware that all of these other features need to be looked at.

Rev. Bonita Grubbs asked of the ways that the opinions and experiences of recipients could be collected. Kate expressed appreciation for her comments and added that the collection of comments is required and aligns with the values of DSS. She talked about several things DSS does including a CHN workgroup that consists of 15 Medicaid recipients, the BHP family advisory committee and the MFP steering committee. Kate finds it is difficult to directly get recipients and providers to MAPOC and that is the specifically who federal regulations say need to be included. This will sit along MAPOC and will be a vehicle for formal Department convened meetings.

Rep. Abercrombie commented that the MAPOC could expand and include the advisory committee. She asked for clarification on when CMS required this to be in effect. Joel Norwood stated that the federal regulations on access are effective Jan 1st. The Care Advisory Committee has been on books for a while. Kate stated that the waivers are not affected by the rule and will not be included in the access plan.

Mary Alice Lee listed some of the active clinicians and those who work with consumers who sit on this committee. Kate agrees and stated that it has been successful but the separate group that advises will have direct participation by consumers. The federal law makes it clear that it is the members themselves. She added that this council has a valuable role and that won't be changed but it will help to have a group for specific meetings that can be held at different times with more flexibility and participation based on a rolling, refreshing membership. Kate hopes the two groups will be well integrated and it would be built into the MAPOC agenda. Mary Alice believes it would be important to have a liaison between the two groups. Dr. Rob Zavoski added that MAPOC has one of the members of the managed care council and everyone who wants to be involved should be involved.

Rod Winstead went through the second half of the presentation on the Medicaid Medical Care Advisory Committee (See p. 24 of the above attachment).

Ellen expressed her hope that the meetings would be open with advanced notice. Kate stated that a formal structure would be set for the committee and she talked about other meetings and the public comment period.

Amy Gagliardi asked if there would be a larger amount of Medicaid members or how the membership would be. Kate discussed there being even participation and that there should be a majority of recipients as members. DSS welcomes comments and suggestions and will rely on the community partners to help broadcast this.

Mary Alice thinks it would be very useful to hear what DSS is currently doing to solicit member input. She questioned if it would be possible to have some sort of meeting with the CHN member advisory workgroup. Kate stated that DSS is ready to provide a report on CAPS and that more details would be presented to the Care Management Committee. She believes that bringing some of the advisory groups together would be a good idea. Rep. Abercrombie acknowledged that

everyone agrees to this and it should be put on a future agenda. There was discussion on better ways to use technologies so everyone knows what is going on. Rev. Grubbs stated she would assume that one of the legislators would be involved in the process. Rep. Abercrombie talked about the role and asked Kate for her thoughts. Kate agreed and would talk to the Commissioner.

Kate discussed the DSS response to the Caring Families Coalition and how important communicating to members is. DSS values these advocacy groups and the time they take to share their concerns to us and therefore replied with a detailed response letter. (See attachment). https://www.cga.ct.gov/med/council/2016/0311/20160311ATTACH_%20DSS%20Information%20Letter%20to%20Caring%20Families%20Coalition%20.pdf

Kate added that as of this week DSS is soliciting a comments period to gather information (RFI) of which the results would be used to issue a request for proposal (RFP) for NEMT. DSS cares about feedback and wants more of it. Kate added that DSS relies on its partners to broadcast what we do have and her hope that we can work together and promote this. Cynthia DelFavero talked about the booklet that is distributed to every new Medicaid member in a welcome packet. Ellen loved the response from DSS and added that it was the first time in her memory that there has been such a detailed response. She discussed the need to talk about how people prepare for the August 1st transition. Rep. Abercrombie agreed and asked to talk about it after the DHP presentation.

III. Chris Savold began the DHP presentation (See attachment). https://www.cga.ct.gov/med/council/2016/0311/20160311ATTACH_CT%20Dental%20Health%20Partnership%20Presentation.pdf

Marty Milkovic continued the presentation speaking specifically to outreach.

Sen. Gerratana thanked Marty and Chris for their presentation.

Commissioner Ritter commented on the positive information and current work on the over 60 population. She asked if an analysis could be done on that population. Marty stated that the DHP and himself are very active in working towards an older adults collaborative.

Suzanne Lagarde acknowledged Marty and the team and the utilization results being seen because the rates are so much better for children.

Dr. Zavoski acknowledged the dental program and Dr. Balaski who is currently on Medical leave.

Sen. Gerratana commented on the data which shows prevention and outreach works. Marty added that the increase in preventative services has lead to a decrease in other services.

Ellen asked if the Department wanted to walk through the documents distributed on the outreach to Husky A parents. She added that she had provided a tip sheet to DSS. Deb Polun asked for clarification on whether outreach was from DSS or Access Health. Marc Shock and Emanuela Cebert of AHCT laid out the role in outreach and the partnership between the two bodies. DSS is first focused on those losing coverage and if they can qualify for any other Medicaid services. After that, Access Health uses its marketing experience to handle getting those enrolled who do not qualify for other forms of Medicaid. The Department sends out notices urging those currently covered to update information in the Access Health system. Emanuela discussed the postcards

sent out that say you should check your coverage. Posters coincide with these postcards and are placed at health centers, hospitals and community centers. Access Health will be making phone calls directly to these people as well as using digital/ social media. We have been in touch and will be having posters. Deb felt that some of the communication may have been ignored last summer because consumers see Access Health and not the Department of Social Services.

Ellen stated that a good number of people will be uninsured based on the first cohort and she is worried about people signing up for things that are scams. She added that it is very important to get people information on the transition to being without health coverage. Emanuela talked about the work with community health centers, town hall meetings and enrollment fairs.

Mary Alice stated that CT Voices for Children is ready to help send out the message. She shared her concern with children who could inadvertently lose coverage because of their parents. Emanuela stated that a sample showed 50 percent of kids still remained on HUSKY and 50 had aged out. Mary Alice suggested it could be a point of concern based on other states. Marc stated that it is a little different because DSS has the capacity to do auto enrollment.

Cynthia DelFavero asked about communication and issues with people hanging up when they call because they don't know who is calling. She suggested that callers use partner groups for specific populations. Marc believed that was a great suggestion and they should say you're calling on behalf of the health plan.

Mary Alice questioned if AHCT would speak at some point on how they are gearing up for this since it is happening outside of the regular enrollment period. Emanuela stated that the call center is budgeted for the max amount and they could do a follow up.

Sen. Gerratana thanked them for the information provided.

IV. Subcommittee Report (See Attachment)
https://www.cga.ct.gov/med/council/2016/0311/20160311ATTACH_February%20-%20March%20Subcommittee%20Repot.pdf

Sen. Gerratana listed who would not be in attendance.

Christine Bianchi asked Deb to read an update on the Consumer Access Subcommittee.

Rep. Johnson stated when the Complex Care Committee would be meeting and what would be discussed. Ellen Andrews is the new co-chair, replacing Sheila Amdur. Ellen discussed some of the other issues that would be looked into and ongoing conversations about ways to integrate meetings.

Kate thanked the Chairs and the clerk for facilitating the Medicaid forum and helping to get information out. She discussed her conversations with other states and the Medicaid reform partnership with legislative leaders that is important for CT. Kate added that while everyone may not always agree, it is very important to have the dialogue and transparency that enables our State to accomplish things. Rep. Abercrombie felt her colleagues were very impressed by the amount of positive information from the informational forum and pride in our state's Medicaid program. She agreed that open dialogue is so important. Rep. Abercrombie thanked DSS for all the work they do and the challenges and the willingness to show up and talk. She also thanked

the advocates for their work. Sen. Gerratana thanked Rep. Abercrombie and the ability to have open discussions from a variety of perspectives.

V. There will be no meeting held in April.

The meeting was adjourned at 11:54AM.

MEETING MINUTES

Friday, May 20, 2016

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:37AM by the chair, Sen. Gerratana. She thanked everyone for being present and introduced new members.

Introductions were made by those in attendance.

II. Kate McEvoy remarked on the materials and stated that they are posted on the DSS website under special for service partners. She discussed the webpage and its contents.

Melissa Garvin started the Presentation on the ConneCT Public Dashboard. (See Attachment) https://www.cga.ct.gov/med/council/2016/0520/20160520ATTACH_ConneCT%20Dashboard%20Update.pdf

Melissa went through the benefits center system structure, the May 2016 ConneCT public dashboard and the benefit center wait times over the past 13 months.

Mary Alice Lee asked if wait time was in the benefit center queue. Melissa responded that it is. Mary Alice asked when the contract was signed with Viora. Melissa answered that just prior to July 2013 is when the process improvement began. It was business related not system related.

Deb Polun asked if there was any plans for when the HUSKY A parents lose their TMA. Melissa stated that any time there is a mass notification we are notified in order to plan for a higher number of callers. She added that the new offices can take on additional calls if necessary. Rob Blundo added information on the work AHCT does with its Maximus call center and how they respond to higher call volume.

Sheldon Toubman asked about the process improvement project, and what the goal was for wait times. He stated that CHN has to answer 90 percent of their calls within 60 seconds and questioned where DSS plans to get to. Melissa talked about the process improvement project and what it involved. She stated that the goal is to always be lower and eligibility is not as easy to time as is with other call centers. Melissa discussed the process time varying wildly every month for a variety of factors. She added that the goal is immediate answering but we understand that the variables affect the time and need to be as efficient and accurate as possible. Sheldon stated DSS knows and can analyze what would be the goal for an average wait time. Melissa cautioned the comparisons of the call centers and talked about the functions and different levels and needing to stick to a range rather than a goal.

Cynthia DelFavero asked for a breakdown of the 80,000 calls. Melissa stated that 150,000 is the total monthly average for the main number and referred to the information on slide 5.

Rep. Srinivasan asked what was being compared in the call time waits. Melissa added clarification on the wait times depending on the week vs. monthly. The monthly snap shots are

on slide 4. She stated that in April it was at 9 minutes and most of the days are extremely low but on high days there can be higher times that affect the average. Rep. Srinivasan asked if there was the capability to do call backs in the future. DSS does not currently have the call back system but they continue to work towards improvement and innovations. Rep. Srinivasan asked about the IVR which is available in English and Spanish.

Stan Soby asked what the number of staff available on a given day is and what the number would be when a notice goes out. Melissa discussed that there are currently 300 licenses for the system of which, 190 are typically in use. Stan Soby asked if the IVR included dropped calls. DSS cannot determine if someone calls back within the current system. Ellen Andrews asked if you can identify when people are dropped and if you track whether they lose coverage. Melissa stated that repeat caller identification is limited by the technology they use but they do know the abandonment rate. Comparing this to other data is something that can be looked at for ImpaCT.

Sen. Gerratana asked what someone could expect with the interactive voice response (IVR). Melissa responded that the IVR picks up right away with no delay and she doesn't have the actual selections in front of her. All the information is recorded for when they go into the benefit center including if a client uses a PIN, which will connect to EMS. Kate thanked Melissa and Marvin for the presentation and thanked the Council for their questions. She talked about the need to broadcast that there is fluctuation across the month and that the second and third weeks for requests that are not urgent would be a better time to call. There are also many pieces that can now be managed completely online without needing to call the benefits center.

Sen. Gerratana discussed having the next update in September.

III. Kristen Dowty started the presentation on the HUSKY A transition (See Attachments). https://www.cga.ct.gov/med/council/2016/0520/20160520ATTACH_HUSKY%20A%20Transitions%20Update.pdf

Rob Blundo went through the Access Health reporting requirements.

Rep. Johnson thanked them for the presentation and asked if the people migrating out of HUSKY A have adequate information on their options. These persons receive a notification upon termination.

Suzanne Lagarde shared what she believed would happen with those that would lose insurance. Rob introduced Emanuela Cebert who is handling the outreach between AHCT and DSS. The information is being used for outreach and to make sure that the means are available for effective outreach and follow up. Emanuela discussed the outreach plan for this population. She provided an update on the schedule that was distributed at the last meeting. She talked about what is currently happening and what will be happening in the immediate future.

Rep. Johnson asked about those who enroll and find themselves eligible for Medicaid because their income is reduced based on their deductible. Kate McEvoy stated the deductible could count as a spend down to qualify for HUSKY C. The reported changes would show up and a person could possibly transition into HUSKY C. Rep. Johnson shared her concern that the deductibles would be too high. Kristen added that it was something to consider and talked about the outreach DSS does to find people who may be pregnant or disabled and the work with CHN to identify this through claims data.

Rep. Rovero asked who pays for visits when someone is uninsured. Kate McEvoy stated that Emergency care gets reimbursed through Medicaid for uninsured. She talked about how historically Hospitals were compensated for the uninsured but now the premise is that many more people are covered reducing the uninsured and therefore less needed to cover this through the ACA. Kate added that less that 5 percent of people are uninsured in CT and the funds have been reduced but not completely eliminated. Suzanne stated that if any of the people come to a FQHC there is a slide based on income. Mary Alice Lee talked about the letter that would be going out to persons losing their TMA and asked why they would not be directed to ConneCT. Kristen stated that through Access Health, based on questions, they would be directed to ConneCT if applicable. The redetermination dates for parents will push back the children to make them align. Deb Polun talked about the notifications going out. Emanuela stated that the letters sent would be branded with DSS and Access Health CT logos.

Ellen Andrews talked about the letter and shared her concerns. She believes that people should be informed of what could happen based on transitioning to new services or being uninsured. Emanuela said that they were aware of these comments and are discussing ways to inform persons about this. Beth Cheney agreed with what Ellen said and expressed her concerns on how persons are notified.

Catherine Risigio-Wickline talked about her concern with plans not covering therapy services and if families are educated to that. Emanuela talked about what Access Health does to educate people when they are enrolling to find the best plan for themselves. They are constantly reminded of what they should do based on their specific needs. Kristen Dowty provided clarification that children would not be affected but does understand the concern with HUSKY B in general. Kate talked about the benefits checklist that have been developed by CHNCT and would be circulated. Rep. Johnson asked why there was a limitation on behavioral health services. Rob Blundo stated that there are ACA requirements, as well as those of the state and exchange, that set standards that could be reviewed in the future.

Sheldon Toubman acknowledged the Legislature for not cutting more HUSKY A parents and for requiring DSS report to MAPOC to allow the Council to monitor what is happening. He appreciated the chance to comment on the letter that would be sent out and amended some of his comments because he didn't fully understand the intention of the letter. Sheldon believes the problem is that the Health insurance being offered is unaffordable and he wants comments in the notice to acknowledge that people may not have insurance following the TMA period.

Mary Alice went through the report on HUSKY program coverage for parents she distributed (See Attachment).
https://www.cga.ct.gov/med/council/2016/0520/20160520ATTACH_%20CT%20Voices%20for%20Children;%20HUSKY%20Income%20Eligibility%20Cut.pdf

Rep. Johnson thanked Mary Alice Lee for the work she has done and talked about her hopes, CT can start a program to help cover deductibles. Ellen talked about concerns with wrap arounds and the match and benefits the State gets through Medicaid. She feels it is not be best to move people around and it may be best to reconsider putting the people back on HUSKY.
Mary Alice also found that restoring the coverage was the best. She added that whole families can no longer get the same coverage and it's unfortunate that we go after this population for money, causing constant changes in eligibility. Rep. Johnsons added that if there was a way to create stability with a wraparound it might be the best way.

Sen. Gerratana thanked them for the presentation and shared how important this is to the Council. The next update will be in September.

Kate McEvoy gave a brief overview of the Innovation Accelerator Program on Medicaid-Housing Partnerships which she plans to talk about more during the next meeting. She discussed the program, its general goals, and the many partners involved. She acknowledged Rod Winstead who discussed the Medicaid Medical Care Advisory Committee that was talked about at the last meeting. The Department has reached a point of member recruitment which will be posted on the website and sent to MAPOC members.

Sen. Gerratana talked about CT Mirror article on housing. Kate discussed the article which illustrates that housing stability is important with evidence based facts. She talked about the work that is currently happening in CT.

IV. Subcommittee Report (See Attachment)
https://www.cga.ct.gov/med/council/2016/0520/20160520ATTACH_March,%20April%20and%20May%20Subcommittee%20Repot.pdf

Sen. Gerratana mentioned the new committee established in Public Act No. 16-142 within MAPOC to make recommendations on support systems for children and young adults with developmental disabilities. It will be effective July 1, 2016 if signed by the Governor.

Ellen talked about the Palliative Care webinar and what the future meetings of the Complex Care Committee will be looking at. Rep. Johnson thanked Ellen for her work and talked about the cost shifting that would be looked into by the Complex Care Committee. She thanked Sheila, who recently stepped down as the chair, for her work on the committee.

V. The meeting was adjourned at 11:29 AM.

MEETING MINUTES

Friday, June 10, 2016

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at by the chair, Rep. Abercrombie, at 9:42AM.

Introductions were made by those in attendance.

II. Kate McEvoy began by announcing that on Monday the Department issued an RFP for the Medicaid Quality Improvement and Shared Savings Program (MQISSP). She thanked the Care Management Committee for all of their work and input.

Ellen thanked DSS for the unique experience and allowing extensive input from the Care Management Committee. Rep. Abercrombie thanked everyone for their efforts. Kate referenced the "special for service partners" area of the DSS website.

Kate began the overview of the Innovation Accelerator Program on Medicaid-Housing Partnership (See Attachment).
https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_Innovation%20Accelerator%20Program%20on%20Medicaid-Housing%20Partnerships%20Presentaion.pdf

Colleen Harrington discussed the supported housing program through DMHAS. She talked about the infrastructure for a Medicaid billing program and the lift Housing providers would be receiving.

Rep. Abercrombie thanked Kate and asked that anyone interested on sitting on the steering committee send a request to Rich, the council's clerk.

Rep. Conroy asked how DSS decides which towns receive people being placed. Kate discussed the person centeredness and working with the person through transition supports to help coordinate where they will go.

Rev. Bonita Grubbs applauded the new initiative and asked if this was targeted to single individuals and how the family is tackled. Kate stated that CMS is focused on individuals with disabilities who can be a part of families. Most of the literature and policy is on the person but there is a lot of work to be done with families not just individuals.

Tracy Wodatch asked if she knew what the plan was with the work the commission on aging did on livable communities. She provided context on the medication administration rate reduction that she would be discussing later in relation to the housing initiatives. Kate believes the work on livable communities will continue but that's something to look into. She discussed Tracy's comments on strategies from home health supports to self-management.

Ellen Andrews expressed how exciting and important this project is in finding smart and safe ways to save money. She hopes to look into the data match and believes the impact on

communities will be benefited in the addition to the individual and feels local officials should be included. Kate reinforced the data matching and believes the local governances should be included. She talked about what Hawaii recently did towards homelessness and how CT's approach was much different.

Dr. Alex Geertsma talked about his perspective on the medical placement of foster children and how it directly relates to the family and possibly homelessness. He finds there is great potential and hopes there is persistence because there are going to be many issues in stability that goes through generations.

Matthew Barret acknowledged the importance of the initiative and talked about CT's history of programs to prevent and end homelessness. He offered his willingness to represent the Council.

Katherine Yacavone talked about persons who are already represented in the project. Kate talked about the work with DOH and its partners to work with the various groups that deal with housing.

Stephen Frayne talked about the issues that occur now with persons who are homeless and need care and asked that short term needs be acknowledged when looking at these long term housing goals. Kate agreed with the barrier issues and talked about a project currently going on in New Haven and looking at that to see how this could work in other areas.

Sheldon Toubman discussed the flexibility in MFP that has helped many individuals. Kate talked about the many variables and person-centeredness.

Catherine Risigo-Wickline discussed Dr. Geertsma' s comments and the need to help children.

III. Dr. Robert Zavoski provided an update on HUSKY Plus Program (See Attachment). https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_HUSKY%20Plus%20Presentation.pdf

Mary Alice asked what the source of referrals is for the children. Dr. Zavoski responded that it varies greatly. Many referrals come from the two children's Hospitals along with the ASO's. Many pediatricians contact the ASO's and sometimes parents make the referrals. Mary Alice asked if they are referred before running out of resources in HUSKY B. Dr. Zavoski said that most referrals come before hand and they try to make the transition as seamless as possible.

Stan Soby asked about the co-pays applying to non-preventative care and what would be covered. DSS uses the same definition as under the ACA. Stan asked if there is any other service limitation in HUSKY Plus. Dr. Zavoski believes the only thing that is not covered is skilled nursing services.

Mary Alice commented on the low enrollment in HUSKY Plus which she finds concerning. She asked Dr. Zavoski if he believes this is because of the benefits under HUSKY B being sufficient. He believes the benefit package provides for more than others do.

Dr. Geertsma asked about the numbers with Autism Services and what the state of the program is. Dr. Zavoski commented on HUSKY B services which are not though Medicaid. Bill Halsey stated that DSS would be happy to give a presentation on Autism Services in the future and gave a brief update of what is happening with the shift of services to DSS. Dr. Geertsma talked about

general impressions with Autistic children and the issues with behavioral health. Dr. Zavoski agreed and talked about the struggle with putting together the Autism network. Kate added that there is a very careful process and they are looking at the provider capacity and difficulties with this nationally. Dr. Geertsma talked about the issue with quality of services vs. quantity. Kate talked about the provider bulletins that are issued with new policies, specifically with Autism, and the amount of information on the parameters of coverage. Rep. Abercrombie referenced the moving of Autism services from DDS to DSS. She hopes that by doing this we will be able to provide better services, more services and get school districts more involved.

Rep. Abercrombie talked about having a forum on Autism Services. Kathy Risigo-Wickline discussed therapy services and the issues she faces with reimbursement for speech language therapists. Bill Halsey talked about the outreach that is done and DSS's willingness to listen to suggestions. Sheldon Toubman stated that he would like to see a presentation on the services and talked about the amount of providers and the problem with access if payments are too low. Bill Halsey stated that when fee schedules are updated the rates are aligned with up-to-date statistics from the Department of Labor and they increase this sometimes based on access. They are hearing that more providers are enrolling and they will continue to look at that.

Mary Alice asked if a child is automatically referred into HUSKY Plus if they are in enrolled in HUSKY B which is not Medicaid. Rep. Abercrombie believes that is something that is important to look at. She referenced a document from CT Voices for Children and thanked Mary Alice Lee for the work that she and the organization does.

IV. Subcommittee Report (See Attachment).
https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_May-June%20Subcommittee%20Repot.pdf

Rep. Conroy stated her excitement to be a part of restarting the Quality Improvement subcommittee. Rep. Abercrombie discussed the work that is being done towards subcommittees.

Amy Gagliardi stated that the Women's Health committee would be meeting on Monday and continuing the discussion on opioid abuse in pregnant women.

Dr. Geertsma stated his hope to speak at the American Academy's upcoming meeting and share his concern that it has been in a position of responding to legislation put forward and believes the Academy needs to look where CT stands towards national issues and take a proactive approach.

Ellen Andrews stated that the Complex Care Committee would be meeting on the 24th and discussed what would be on the agenda.

Rep. Abercrombie referenced the forum on June 16th on the proposed 15 percent reduction in Medication Administration rates. She asked if in last year's budget there was any language about these sorts of cuts being run through the committees of cognizance. Kate discussed the letter that was sent from the Department to the Appropriations and Human Services leadership. She also went through the issue brief on Medication administration and referenced the mastersheet of all home health providers (See Attachments).
https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_Medication%20Administration%20cover%20letter.pdf

https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_%20Issue%20Brief%20on%20Medication%20Administration.pdf
https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_Home%20Health%20Mastersheet%20CY%202015.pdf

Rep. Abercrombie shared her concerns and the potential for ramifications by implementing these cuts. Tracy Wodatch provided background and context on medication administration in homes. She referenced and discussed several Home Health documents that were distributed (See Attachments).
https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_INVITATION%20June%2016%20LOB%20Public%20Forum%20Behavioral%20Health%20Community%20Based%20Challenges.pdf
https://www.cga.ct.gov/med/council/2016/0610/20160610ATTACH_Methods%20for%20Assuring%20Access%20to%20Covered%20Medicaid%20Services.pdf

Tracy discussed many of the cost savings initiatives that were enacted. She reiterated the Home Health forum that would be taking place and who was invited. She shared the many concerns Home Health has with the 15 percent cut and potential setbacks. There is a 30 day period to send in comments on the State Plan Amendment. Ann Foley thanked Tracy and the Association for their work and partnering with OPM to try and address the situation. She discussed the context of nursing home rebalancing and what has been tried to be accomplished over the past 5 years. Ann talked about the budget issues and OPM does not feel they can carry the savings into 2017. Kate recognized the home health partners in rebalancing and discussed the initial premise of the issues for community services. She talked about delegation and med boxes and the need to make up means in the budget because of the low returns from these. Kate asked for help in the integration of persons into the community through culture and expectations.

Colleen Harrington agreed with Tracy that they are not alone. She talked about the work of DMHAS through Beacon with local mental health authorities (LMHA) on needing to move things forward through lower cost alternatives. Tracy added that she agreed with the comments of Colleen and Kate and the need to work with LMHAs. Rep. Abercrombie encouraged people to attend the forum and believes this is a continuing discussion.

Sheldon Toubman referenced the Husky A Parents who lost their Medicaid coverage and would be losing their TMA at the end of July. The advocates have put together a document outlining how they feel to appropriately help the parents through their coverage transition. Katherine Yacavonne added that FQHC's have outreach and enrollment specialists to help people through the transition.

V. Rep. Abercrombie announced the next meeting date and asked for thoughts on what should be on the agenda. DSS will present on Autism Spectrum Disorder. Alex Geertsma expressed that he worried that an important topic should be deferred until a meeting not during the summer. Rep. Abercrombie said that she feels that it is important to start the conversation during the July meeting and there can be follow-up at the September meeting. She also stated that the Council should receive a HUSKY A update. Mary Alice asked that the Dental cuts and potential impacts be on the agenda for July. Tracy asked for a follow-up on the medication administration rate cut.

Dr. Geertsma asked if all MAPOC meetings are on CT-N. The clerk explained that generally the Council meetings are on CT-N outside of session. The links to the CT-N recordings are posted on the Council's webpage.

Rep. Abercrombie thanked everyone for their attendance.

The meeting was adjourned at 12:22PM.

Richard Eighme
Administrative Assistant